

EMT-BASIC RECERTIFICATION FORM

Continuing Education Recertification Program

EMT Number

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Date _____

DIVISION	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	1			
Airway	2			
Patient Assessment	3			
Medical/Behavioral (see sub categories)				
Gen. Pharmacology/Respiratory/Cardiac	4			
Diabetes/Altered Mental/Allergies	2			
Poisoning/Environmental/Behavioral	2			
Trauma	4			
Obstetrics/Gynecology	2			
Infants and Children	2			
Elective	2			
TOTALS	24			

CPR Certification

As the participant's CPR Instructor I hereby verify that the participant has satisfactorily completed and shows competence in:
Adult, Child and Infant 1 & 2 rescuer CPR and Obstructed Airway management

Printed Name of Instructor _____ Signature of Instructor _____ Date _____

*** A COPY OF THE CARD ISSUED MUST ACCOMPANY THIS APPLICATION IF THE INSTRUCTOR DOES NOT SIGN***

Date _____

Additional 48 Hours of Continuing Education – Must include mandatory training in Geriatrics and WMD as noted!

Date	Topic	Hours	Date	Topic	Hours
	Geriatrics – 3 hours minimum				
	WMD/Terrorism – 3 hours minimum				
TOTAL HOURS			TOTAL HOURS		

Skill Competency Verification

SKILL	QA/QI	Direct Observation
Patient Assessment (Medical and Trauma)		
Airway / Ventilation (Simple Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask one and two rescuer)		
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction splinting)		
Spinal Immobilization (Seated and Supine)		
Cardiac Arrest / Automatic External Defibrillator (AED)		

As the Physician Medical Director or Training Officer for the Participant's Continuing Education Program I hereby affix my signature attesting to proficiency in all skills outlined above.

Printed Name of Medical Director / Training Officer	Signature of Medical Director / Training Officer	Date
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Date _____

I hereby affirm that all statements on this recertification form are true and correct, including all copies of cards, certificates and other required verification. It is understood that false statements or documents submitted with the intent to falsely recertify may be grounds for revocation of certification and applicable civil and criminal penalties. It is also understood that the Bureau of Emergency Medical Services or its designee may conduct an audit of the activities listed herein at any time. **This form must be mailed and postmarked no less than 45 days prior to your current expiration date!**

Signature of Participant

Signature of Sponsoring Agency Contact / Coordinator

Signature of Sponsoring Agency Contact / Coordinator

Date _____